SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: U323 0110, U324 0110	SERFF Tr Num: AEGB-126459450	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 44709
Sub-TOI: L08.000 Life - Other	Co Tr Num: U323 0110, U324 0110	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Theresa Meyers	Disposition Date: 02/01/2010
	Date Submitted: 01/27/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: U323 0110, U324 0110	Status of Filing in Domicile: Pending
Project Number: U323 0110, U324 0110	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/01/2010	Explanation for Other Group Market Type:
	State Status Changed: 02/01/2010
Deemer Date:	Created By: Theresa Meyers
Submitted By: Theresa Meyers	Corresponding Filing Tracking Number: 10000234

Filing Description:

Re: WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO NAIC # 468-91413
U323 0110 – WRL Express Application Part I
U324 0110 – Medical Supplement Part II of WRL Express Application

Dear Sir/Madam:

Please find attached a copy of the above referenced forms. These are new forms and are not intended to replace any

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
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TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

forms previously approved by your Department. These forms are being submitted in final printed form in which they will be distributed to Insureds. These forms are subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officers' signatures.

WRL Express Application Part I – This is an individual life insurance application that will be used with our life portfolio.

Medical Supplement Part II of WRL Express Application – This is a supplemental medical life application to be used with the WRL Express Application Part I.

We plan to make these forms available electronically. It is our intent to use these forms in a variety of electronic environments, including a laptop and web-based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via a secured socket layer/secured line. The information contained in the application will be transmitted to our administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act. We also intend to use these forms in a traditional manner whereby the Owner/Applicant signs the application in ink and submits the application to the Company.

We hereby certify that any electronic signature we obtain will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. We also certify that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

A copy of the application, identical to the filed form, will be printed and made part of any policy issued.

Please contact me if you have any questions or need additional information.

Sincerely,

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

Theresa Meyers
Policy Analyst
Contract Development
(319) 355-7520 (collect)
Fax #: (319) 355-2501
thmeyers@aegonusa.com

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Company and Contact

Filing Contact Information

Theresa Meyers, Policy Analyst	thmeyers@aegonusa.com
4333 Edgewood Rd. NE	319-355-7520 [Phone]
MS 2225	319-355-2501 [FAX]
Cedar Rapids, IA 52499	

Filing Company Information

Western Reserve Life Assurance Co. of Ohio	CoCode: 91413	State of Domicile: Ohio
4333 Edgewood Road NE	Group Code: 468	Company Type:
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(319) 355-7888 ext. [Phone]	FEIN Number: 43-1162657	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50.00 per form X 2 forms = $100.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	$100.00	01/27/2010	33836746

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
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TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/01/2010	02/01/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	WRL Express Application	Theresa Meyers	01/29/2010	01/29/2010
Form	WRL Express Application	Theresa Meyers	01/29/2010	01/29/2010

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
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TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Disposition

Disposition Date: 02/01/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form *(revised)*	WRL Express Application		Yes
Form	WRL Express Application	Replaced	Yes
Form	WRL Express Application	Replaced	Yes
Form	Medical Supplement Part II of WRL Express Application		Yes

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Amendment Letter

Submitted Date: 01/29/2010

Comments:

Mr. Linda Bird,

We have re-attached the U323 0110 application form. The wrong form was attached in the Form Schedule Tab.

Thank you,

Theresa Meyers

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
U323 0110	Application/Enrollment Form	EWRL Express Application	Initial				51.000	U323 0110 STD.pdf

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Amendment Letter

Submitted Date: 01/29/2010

Comments:

Ms. Linda Bird,

We are amending the U323 0110 WRL Express Application. In the Taxpayer Indentification Certification section on page 9 we have changed the brackets to parenthesis for (strike this clause if it is incorrect).

Please feel free to contact me if you have any questions.

Thank you,
Theresa

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
U323 0110	Application/Enrollment Form	WRL Express Application	Initial				51.000	U323 0110 STD.pdf

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Form Schedule

Lead Form Number: U323 0110, U324 0110

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	U323 0110	Application/ Enrollment Form	WRL Express Application	Initial		51.000	U323 0110 STD.pdf
	U324 0110	Application/ Enrollment Form	Medical Supplement Part II of WRL Express Application	Initial		50.600	U324 0110 STD.pdf

Western Reserve Life Assurance Co. of Ohio
Home Office: Columbus, Ohio
Mailing Address: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]
Administrative Office: [PO Box 5068, Clearwater, FL 33758-5068]

WRL Express Application Part I

1 PROPOSED PRIMARY INSURED

Last Name | First Name | M.I.

Street Address (Cannot be a PO Box)

City | State | Zip

Daytime Telephone Number | Date of Birth (Month/Day/Year) | Place of Birth (State/Country)

Social Security Number | Sex | Driver's License Number | State

ft. in. | lbs.
Height | Weight | Marital Status

2 APPLICANT/OWNER The person or entity exercising the policy's granted rights.

☐ Same as proposed Insured
If ownership is a corporation, partnership or institutional body, please complete the Entity Certification of Authority Form. If ownership is a trust, please complete the Trustee Certification Trust Form. Attach a copy of the first page and the signature page of the trust.

Last Name | First Name | M.I.

Street Address (Cannot be a PO Box)

City | State | Zip

SSN/Tax ID | DOB / Trust Date | Relationship to Insured

Are you a citizen of ☐USA ☐Other Country _____ Type of VISA _____

3 PRIMARY BENEFICIARY If percentage shares are not listed below, proceeds will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

4 CONTINGENT BENEFICIARY If percentage shares are not listed below, proceeds will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

5 INSURANCE

Plan:

☐ WRL Freedom Global IUL
☐ WRL Freedom Index UL
☐ WRL Freedom Elite Builder II VUL
☐ WRL Freedom Choice Term II ☐10 ☐15 ☐20 ☐30

Specified Amount: $ _____

Death Benefit Option: (if applicable)

☐ Level Benefit ☐ Increasing Benefit
☐ Increasing to Age 70 then grade to Level

Additional Benefits: Not all items available with all products.

☐ Primary Insured Rider Plus $ _____
☐ Base Insured Rider $ _____
☐ Disability Income Rider (monthly benefit) $ _____
☐ Disability Waiver of Monthly Deductions Rider
☐ Disability Waiver of Premium Rider
☐ Accidental Death Benefit Rider $ _____
☐ Critical Illness Rider $ _____
☐ Inflation Fighter Rider

Life Insurance Compliance Test: (if applicable)

☐ Guideline Premium Test (GPT)
☐ Cash Value Accumulation Test (CVAT)

Rate Class:

☐ Preferred Elite ☐ Preferred Plus ☐ Preferred
☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

Additional/Other Insureds:

☐ Please complete Additional/Other Insured Sections 15 and 16
☐ AIR Disability Income Rider
(monthly benefit) $ _____

Children's Benefit Rider:

☐ Please complete Child Insured Section 17

6 PREMIUMS PAYABLE

6a Initial Planned Premium $ _____
☐ Electronic (bank draft) _____ Draft Date (1st thru 28th) ☐ Direct Bill ☐ Other _____
☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly

6b A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.

_____
Secondary Addressee

_____
Street Address (Cannot be a PO Box) City State Zip

7 PREMIUM ALLOCATIONS

Global IUL & IUL

Indicate your premium allocation percentages below. Total must equal 100% and must be whole percents only.

_____ % Index Account
_____ % Basic Interest Account
100% Total

VUL

Complete and sign the Premium Allocation Options form.

8 INFORMATION ABOUT THE PROPOSED PRIMARY INSURED

8a Best days and times to call for telephone interview? _____

Best time to call to set up your exam? _____ Telephone Number: _____

8b Name of Employer: _____ Occupations/Duties: _____

_____ _____

8c Gross Income Current Year $_____ Gross Income Previous Year $ _____

Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange

☐ Other _____

Net Worth $_____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

8d Are you a citizen of ☐ USA ☐ Other Country_____ Type of VISA _____

8e How many years has the proposed Insured resided in the USA? _____

8f Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

9 INFORMATION ABOUT PROPOSED INSUREDS

Has any proposed Insured:

9a Used TOBACCO or any other product containing nicotine in the past 5 years? ☐ Yes ☐ No

If Yes, please give type and date last used:

Type: _____ Date Last Used: _____

9b To the best of your knowledge and belief, during the last 10 years, been diagnosed or treated by a licensed member of the medical profession for heart, liver, kidney, lung, brain or mental or nervous disorder, stroke, diabetes, cancer, AIDS or ARC (AIDS Related Complex), alcohol or drug abuse? ☐ Yes ☐ No If Yes, please provide personal physician or clinic information and details:

Name:_____

Address: _____

Telephone Number: _____ Details (including date last consulted): _____

_____

_____

9c Flown in the past 2 years or plan to fly within the next 2 years, except as a passenger on a regularly scheduled flight?
☐ Yes ☐ No If Yes, complete Avocation & Aviation Questionnaire.

9d Within the past 2 years, participated in:

a) Aeronautics such as hang-gliding, ballooning, ultra-light flying or skydiving? ☐ Yes ☐ No

b) Organized motor vehicle, motorcycle, boat or powered vehicle racing? ☐ Yes ☐ No

c) Skin or scuba diving, mountain climbing, canyoneering, rodeos or competitive skiing? ☐ Yes ☐ No

If Yes, complete Avocation & Aviation Questionnaire.

9e Had your driver's license suspended, restricted, revoked, or been cited for a moving violation in the past 5 years? ☐ Yes ☐ No
If Yes, please explain: _____

_____

_____

9f Been convicted of a misdemeanor (other than a minor traffic violation) or felony, or been on probation or parole in the past 10 years?
☐ Yes ☐ No If Yes, please explain: _____

_____

_____

10 OTHER INSURANCE FOR ALL PROPOSED INSUREDS: In force or for Replacement

10a Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain. _____ ☐ Yes ☐ No

_____

_____

_____

10b Is there an application for life, disability, accident, sickness or critical illness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent/Registered Representative's Report. ☐ Yes ☐ No

10c Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

10d Does any proposed Insured have existing life, disability, accident, sickness or critical illness insurance or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of Insurance	Year Issued	Replacement?
					☐ Yes ☐ No
					☐ Yes ☐ No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ _____

11 SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY (VUL only)

11a Have you, the proposed Primary Insured, and Applicant/Owner, if other than the proposed Primary Insured, received the current Prospectus for the policy? ☐ Yes ☐ No

11b **Do you understand that the Death Benefit may be variable or fixed under specified conditions?** ☐ Yes ☐ No

11c **DO YOU UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE ENTIRE AMOUNT OF THE POLICY CASH VALUE MAY INCREASE OR DECREASE DEPENDING UPON THE INVESTMENT EXPERIENCE?** ☐ Yes ☐ No

11d With this in mind, is the policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No

12 TRANSFER AUTHORIZATION – TO BE COMPLETED BY APPLICANT/OWNER (VUL only)

(See Prospectus for transfer procedures.)

Your policy applied for, if issued, will automatically include transfer privileges described in the applicable prospectus. These privileges allow the Owner and the registered representative of record to make transfers, where permitted and to change the allocation of future payments unless declined below.

Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

☐ The registered representative does **not** have authority to make transfers or change payment allocations on my behalf.

13 OTHER INSURANCE–TO BE COMPLETED BY THE AGENT/REGISTERED REPRESENTATIVE

13a Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

13b If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No
(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

13c Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

14 ILLUSTRATION CERTIFICATION

The box below must be checked if a signed illustration is NOT enclosed with an application for any IUL policy.

☐ The Applicant/Owner and the Licensed Agent/Registered Representative represent that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. Licensed Agent/Registered Representative's statement: By signing this application, I, the Licensed Agent/Registered Representative represent that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

15 PROPOSED ADDITIONAL/OTHER INSURED **SPECIFIED AMOUNT $**_____

AIR/OIR Beneficiary: ☐ **Owner** ☐ **Primary Insured** ☐ **Same beneficiary as the base policy**

a. Last Name | First Name | M.I.

b. Address (Cannot be a PO Box) | Apt# | City

State | Zip Code | c. Home Phone | d. Driver License Number | State

e. Sex ☐ Male ☐ Female | f. Date of Birth | g. Place of Birth – State/Country | h. Social Security Number

i. Height ft. in. | j. Weight lbs. | k. Marital Status | l. Relationship to proposed Primary Insured

m. Employer's Name, Address and Phone Number

n. Occupation & Duties | # Years

o. Gross Income Current Year $ _____ Gross Income Previous Year $ _____ Net Worth $ _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

p. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

q. How many years has the proposed Insured resided in the USA? _____

r. Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

s. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

t. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

16 PROPOSED ADDITIONAL/OTHER INSURED **SPECIFIED AMOUNT $**_____

AIR/OIR Beneficiary: ☐ **Owner** ☐ **Primary Insured** ☐ **Same beneficiary as the base policy**

a. Last Name | First Name | M.I.

b. Address (Cannot be a PO Box) | Apt# | City

State | Zip Code | c. Home Phone | d. Driver License Number | State

e. Sex ☐ Male ☐ Female | f. Date of Birth | g. Place of Birth – State/Country | h. Social Security Number

i. Height ft. in. | j. Weight lbs. | k. Marital Status | l. Relationship to proposed Primary Insured

m. Employer's Name, Address and Phone Number

n. Occupation & Duties | # Years

o. Gross Income Current Year $ _____ Gross Income Previous Year $ _____ Net Worth $ _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

p. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

q. How many years has the proposed Insured resided in the USA? _____

r. Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

s. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

t. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

17 CHILDREN'S BENEFIT RIDER **Specified Amount $ _____**

Name	Relationship	Date of Birth (month/day/year)	Height (ft., in.)	Weight (lbs.)

Are all children listed? ☐ Yes ☐ No Are all children living with proposed Primary Insured? ☐ Yes ☐ No

If not, explain why: _____

MEDICAL QUESTIONS – Each question must be individually asked and answered for each child proposed for insurance.

Give the details to "Yes" answers below:

A) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No
2) Asthma, emphysema, chronic bronchitis, tuberculosis, or any other respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No
3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No
4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No
5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Received treatment or counseling for or been advised by a member of the medical profession to limit or discontinue the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test **(excludes any test related to a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection)?** ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

C) To the best of your knowledge and belief, within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? ☐ Yes ☐ No

D) Has any proposed Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Child's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

18 AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION Western Reserve Life Assurance Co. of Ohio (the Company)

Each proposed Insured, and I, the Applicant/Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. I/We agree: (A) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any insurance issued on this application; (B) that the Agent/Registered Representative does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application. No waiver or modification shall be binding upon the Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary; (C) except as provided in the Conditional Receipt, if issued, with the same proposed Primary Insured as on this application, any policy on this application shall not take effect until after all of the following conditions have been met: 1) the minimum initial premium must be paid and received by the Company; 2) the Applicant/Owner has personally received and accepted the policy during the lifetime of and while each proposed Insured is in good health, and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the insurance policy will not take effect if the facts have changed.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have 60 days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

TAXPAYER IDENTIFICATION CERTIFICATION

By signing below, the proposed Owner certifies under penalties of perjury that (1) the Social Security Number or other Taxpayer Identification number ("TIN") listed in this application is my correct TIN; (2) I am not subject to backup withholding due to failure to report interest and dividend income (Strike this clause if it is incorrect); and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed Form W-8BEN or other appropriate Form W-8.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The Internal Revenue Service does not require your consent to any provision of this form other than the certifications required to avoid backup withholding.

Signed at _____ _____ on _____
City State Month/Day/Year

_____ _____
Signature of proposed Insured

Signature of Applicant/Owner if other than proposed Insured
(If business insurance, show title of officer and name of firm)

_____ _____
Owner's e-mail address

Print Agent/Registered Representative's Name

_____ _____
Signature of proposed Additional/Other Insured

Signature of proposed Additional/Other Insured

_____ _____
Signature of Agent/Registered Representative

Agent/Registered Representative Number

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application

dated _____ , with _____ as the proposed Primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Western Reserve Life Assurance Co. of Ohio (the Company), this Receipt is signed by an Agent/Registered Representative or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

There is no conditional coverage for anyone other than the proposed Primary Insured named in the application or for riders or any additional benefits, if any, for which you have applied.

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received by the Company within the lifetime of the proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received by the Company;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable under the Company's rules for insurance at the Rate Class and Tobacco Classification applied for and in the amount and for the plan applied for.

TERMINATION OF CONDITIONAL COVERAGE: Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date Part 1 of the application was signed; (b) the date the Company mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the coverage for which you have applied.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $500,000.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if the proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Western Reserve Life Assurance Co. of Ohio. The Agent/Registered Representative has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the Agent/Registered Representative, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

Dated at _____ on _____ _____

City, State Date Signature of proposed Insured

_____ _____

Signature of Applicant (if other than proposed Insured) Signature of Agent/Registered Representative or Authorized Company Rep

You should retain a copy of this Receipt and Acknowledgment.

Submit with the application and payment.

NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our Agent/Registered Representative may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, [4333 Edgewood Road NE, Cedar Rapids, Iowa 52499].

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

Western Reserve Life Assurance Co. of Ohio
Home Office: Columbus, Ohio
Mailing Address: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]
Administrative Office: [PO Box 5068, Clearwater, FL 33758-5068]

Medical Supplement Part II of WRL Express Application

19 PROPOSED INSURED INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Date of Birth (Month/Day/Year) _____ Marital Status: _____

Social Security No. _____ Height (Ft., In.): _____ Weight (Lbs): _____

Name, address and telephone number of your primary care physician? (If none check box) ☐ None _____

Date and reason last consulted? _____

What treatment was given or medication prescribed? _____

20 MEDICAL INFORMATION ABOUT THE PROPOSED INSURED

A) For the last 180 days have you been actively at work, on a full time basis, at your usual place of business or employment? ☐ Yes ☐ No

B) To the best of your knowledge, have you within the last 10 years, had or been told by a member of the medical profession that you have, or been diagnosed with or treated for:
1) High blood pressure, heart attack, murmur, chest pain, palpitation, anemia, or any disease of the heart, blood vessels or blood? ☐ Yes ☐ No
2) Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis, or any disease or abnormality of the lungs or respiratory system? ☐ Yes ☐ No
3) Cancer, tumor, polyp or cyst? ☐ Yes ☐ No
4) Sugar, protein, or blood in the urine, sexually transmitted disease, or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? ☐ Yes ☐ No
5) Stroke, seizure, epilepsy, fainting, loss of consciousness, tremor, paralysis, multiple sclerosis, or any disease of the brain or nervous system? ☐ Yes ☐ No
6) Anxiety, depression, suicide attempt, or any psychiatric, mental or nervous or emotional condition or disorder? ☐ Yes ☐ No
7) Diabetes, or any disease or abnormality of the thyroid, adrenal, pancreas, pituitary or other glands? ☐ Yes ☐ No
8) Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? ☐ Yes ☐ No
9) Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones or any physical deformity or amputation? ☐ Yes ☐ No
10) Any disease or abnormality of the eyes, ears, nose, throat or skin? ☐ Yes ☐ No

C) To the best of your knowledge, have you within the last 10 years:
1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Sought or been advised to seek treatment, limit or discontinue use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

D) Within the last 10 years, have you been told by a member of the medical profession that you have or had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? ☐ Yes ☐ No

E) Have you had a parent, brother, or sister, who has/had coronary artery or cardiovascular disease, internal cancer, or melanoma, prior to age 60? ☐ Yes ☐ No

F) Has your weight changed by more than 15 pounds in the past year? ☐ Yes ☐ No

21 DETAILS Give details for "No" answer to question 20A and all "Yes" answers to 20B, C, D, E and F

Question No.	Diagnosis, disease, symptom, injury, etc.	Dates	Duration	Treatments/Results?	Name and Address of Attending Physicians and Hospitals

22 CERTIFICATION

I represent that I have read and understand all the statements and answers herein, based on the information provided to the Company during a telephone interview on a recorded line or to this examiner; and in Part 1 of my application; that they are complete and true to the best of my knowledge and belief, and are correctly recorded. I fully understand and agree that if any material information has been omitted from the application, it could provide the basis for the Company to rescind coverage and to refund all my premium as though my coverage had never been in force. I agree that this application and any policy or policies issued based on this application shall constitute the entire contract of insurance. Acceptance of the policy by me is acknowledgment and ratification of any corrections made in the application. I further acknowledge that the information contained in Parts 1 and 2 of this form is being obtained on behalf of Western Reserve Life Assurance Co. of Ohio and that such information will be released to the Company, its agents, employees, representatives and reinsurers.

Date _____ _____
Signature of proposed Insured

_____ _____
Signature of Examiner Print Examiner's Name

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachments:
AR - Rule and Regulation 19.pdf
Flesch Score Certification.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A
Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
Statement of Variability.pdf

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
Home Office: Columbus, Ohio

COMPLIANCE CERTIFICATION
RULE AND REGULATION 19
STATE OF ARKANSAS

Form Number: U323 0110, U324 0110

Date: January 26, 2010

We certify that, to the best of our knowledge and belief, this submission meets the provisions of Rule and Regulation19 as well as all applicable requirements of the Insurance Division of the State of Arkansas.

Cheryl Bock

Cheryl Bock, Director, Product Implementation

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
FLESCH READABILITY CERTIFICATION

Form Number (may vary by state)	**Flesch Score**
U323 0110	51.0
U324 0110	50.6

I certify that the machine scored Flesch Readability score(s) for the above mentioned form(s) is/are accurate.

Cheryl Bock

Cheryl Bock, Assistant Vice President of Contract Development

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
Statement of Variability

U323 0110 – WRL Express Application Part I
U324 0110 – Medical Supplement Part II of WRL Express Application

We have bracketed the variable items in these applications. No change in variability will be made which in any way expands the scope of the wording. Western Reserve Life Assurance Co. of Ohio reserves the right to correct, at any time, any and all typographical errors that do not impact benefits or intent of language.

U323 0110 – WRL Express Application Part I

1. **Mailing Address** (page 1): This may change to another location in the future.
2. **Administrative Office** (page 1): This may change to another location in the future.
3. **Plan** (page 2): The life insurance policy the proposed Insured is applying for.
4. **Death Benefit Options** (page 2): The death benefit the proposed Insured is applying for.
5. **Additional Benefits** (page 2): Additional riders the proposed Insured is applying for.
6. **Global IUL & IUL (page 2):** The percentage distribution the proposed Insured is selecting for premium allocation. New accounts may be added in the future.
7. **Underwriting Address** (page 9): This may change to another location in the future.

U324 0110 – Medical Supplement Part II of WRL Express Application

1. **Mailing Address**: This may change to another location in the future.
2. **Administrative Office**: This may change to another location in the future.

SERFF Tracking Number:	*AEGB-126459450*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*44709*
Company Tracking Number:	*U323 0110, U324 0110*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*U323 0110, U324 0110*		
Project Name/Number:	*U323 0110, U324 0110/U323 0110, U324 0110*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/29/2010	Form	WRL Express Application	01/29/2010	U323 0110 STD.pdf (Superceded)
01/27/2010	Form	WRL Express Application	01/29/2010	U323 0110 STD.pdf (Superceded)

WRL LIFE INSURANCE

Western Reserve Life Assurance Co. of Ohio

MAIL TO:
4333 Edgewood Road NE
Cedar Rapids, Iowa 52499
1-800-322-3796

WRL Express Life Insurance Application

WRL Freedom Global IUL
WRL Freedom Index UL
WRL Freedom Elite Builder II VUL
WRL Freedom Choice Term II

Use this application only if the specified amount requires medical testing. WRL will arrange for all medical testing.

Agent/Registered Representative Comments

Important Reminders	DO: ☐ Complete the entire application (front and back). ☐ Complete application, printing in blue or black ink. ☐ Have applicant initial all changes. ☐ Obtain all required signatures. ☐ Complete and sign the Agent/Registered Representative's Report. ☐ Include certification if a trust or corporation is owner and/or beneficiary of the policy. DON'T: ☐ Use pencil or whiteout. ☐ Use this application for more than 2 Additional/Other Insureds. ☐ Use this application for Juveniles under age 18 except for Children's Benefit Rider. ☐ **Accept or send money for coverage over $1,000,000.00.** ☐ Submit an Agent/Registered Representative check as the initial premium. ☐ Submit starter checks.

Leave with Applicant	THE FOLLOWING PAGES NEED TO BE LEFT WITH THE CONSUMER: ☐ Privacy Notice ☐ Conditional Receipt (If money taken with application) ☐ Notices page (Notice of Investigative Report, Disclosure of Information, and Insurance Information Practices) ☐ HIPAA Authorization for Release of Health Related Information

Western Reserve Life Assurance Co. of Ohio
Home Office: Columbus, Ohio
Mailing Address: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]
Administrative Office: [PO Box 5068, Clearwater, FL 33758-5068]

WRL Express Application Part I

1 PROPOSED PRIMARY INSURED

Last Name | First Name | M.I.

Street Address (Cannot be a PO Box)

City | State | Zip

Daytime Telephone Number | Date of Birth (Month/Day/Year) | Place of Birth (State/Country)

Social Security Number | Sex | Driver's License Number | State

ft. in. | lbs.
Height | Weight | Marital Status

2 APPLICANT/OWNER The person or entity exercising the policy's granted rights.

☐ Same as proposed Insured
If ownership is a corporation, partnership or institutional body, please complete the Entity Certification of Authority Form. If ownership is a trust, please complete the Trustee Certification Trust Form. Attach a copy of the first page and the signature page of the trust.

Last Name | First Name | M.I.

Street Address (Cannot be a PO Box)

City | State | Zip

SSN/Tax ID | DOB / Trust Date | Relationship to Insured

Are you a citizen of ☐USA ☐Other Country _____ Type of VISA _____

3 PRIMARY BENEFICIARY If percentage shares are not listed below, proceeds will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

4 CONTINGENT BENEFICIARY If percentage shares are not listed below, proceeds will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

5 INSURANCE

Plan:

☐ WRL Freedom Global IUL
☐ WRL Freedom Index UL
☐ WRL Freedom Elite Builder II VUL
☐ WRL Freedom Choice Term II ☐10 ☐15 ☐20 ☐30

Specified Amount: $ _____

Death Benefit Option: (if applicable)

☐ Level Benefit ☐ Increasing Benefit
☐ Increasing to Age 70 then grade to Level

Additional Benefits: Not all items available with all products.

☐ Primary Insured Rider Plus $ _____
☐ Base Insured Rider $ _____
☐ Disability Income Rider (monthly benefit) $ _____
☐ Disability Waiver of Monthly Deductions Rider
☐ Disability Waiver of Premium Rider
☐ Accidental Death Benefit Rider $ _____
☐ Critical Illness Rider $ _____
☐ Inflation Fighter Rider

Life Insurance Compliance Test: (if applicable)

☐ Guideline Premium Test (GPT)
☐ Cash Value Accumulation Test (CVAT)

Rate Class:

☐ Preferred Elite ☐ Preferred Plus ☐ Preferred
☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

Additional/Other Insureds:

☐ Please complete Additional/Other Insured Sections 15 and 16
☐ AIR Disability Income Rider
(monthly benefit) $ _____

Children's Benefit Rider:

☐ Please complete Child Insured Section 17

6 PREMIUMS PAYABLE

6a Initial Planned Premium $ _____
☐ Electronic (bank draft) _____ Draft Date (1st thru 28th) ☐ Direct Bill ☐ Other _____
☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly

6b A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.

_____
Secondary Addressee

_____
Street Address (Cannot be a PO Box) City State Zip

7 PREMIUM ALLOCATIONS

Global IUL & IUL

Indicate your premium allocation percentages below. Total must equal 100% and must be whole percents only.

_____ % Index Account
_____ % Basic Interest Account
100% Total

VUL

Complete and sign the Premium Allocation Options form.

8 INFORMATION ABOUT THE PROPOSED PRIMARY INSURED

8a Best days and times to call for telephone interview? _____

Best time to call to set up your exam? _____ Telephone Number: _____

8b Name of Employer: _____ Occupations/Duties: _____

_____ _____

8c Gross Income Current Year $_____ Gross Income Previous Year $ _____

Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange

☐ Other _____

Net Worth $_____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

8d Are you a citizen of ☐ USA ☐ Other Country_____ Type of VISA _____

8e How many years has the proposed Insured resided in the USA? _____

8f Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

9 INFORMATION ABOUT PROPOSED INSUREDS

Has any proposed Insured:

9a Used TOBACCO or any other product containing nicotine in the past 5 years? ☐ Yes ☐ No

If Yes, please give type and date last used:

Type: _____ Date Last Used: _____

9b To the best of your knowledge and belief, during the last 10 years, been diagnosed or treated by a licensed member of the medical profession for heart, liver, kidney, lung, brain or mental or nervous disorder, stroke, diabetes, cancer, AIDS or ARC (AIDS Related Complex), alcohol or drug abuse? ☐ Yes ☐ No If Yes, please provide personal physician or clinic information and details:

Name:_____

Address: _____

Telephone Number: _____ Details (including date last consulted): _____

_____

_____

9c Flown in the past 2 years or plan to fly within the next 2 years, except as a passenger on a regularly scheduled flight?
☐ Yes ☐ No If Yes, complete Avocation & Aviation Questionnaire.

9d Within the past 2 years, participated in:

a) Aeronautics such as hang-gliding, ballooning, ultra-light flying or skydiving? ☐ Yes ☐ No

b) Organized motor vehicle, motorcycle, boat or powered vehicle racing? ☐ Yes ☐ No

c) Skin or scuba diving, mountain climbing, canyoneering, rodeos or competitive skiing? ☐ Yes ☐ No

If Yes, complete Avocation & Aviation Questionnaire.

9e Had your driver's license suspended, restricted, revoked, or been cited for a moving violation in the past 5 years? ☐ Yes ☐ No
If Yes, please explain: _____

_____

_____

9f Been convicted of a misdemeanor (other than a minor traffic violation) or felony, or been on probation or parole in the past 10 years?
☐ Yes ☐ No If Yes, please explain: _____

_____

_____

10 OTHER INSURANCE FOR ALL PROPOSED INSUREDS: In force or for Replacement

10a Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain. _____ ☐ Yes ☐ No

_____

_____

_____

10b Is there an application for life, disability, accident, sickness or critical illness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent/Registered Representative's Report. ☐ Yes ☐ No

10c Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

10d Does any proposed Insured have existing life, disability, accident, sickness or critical illness insurance or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of Insurance	Year Issued	Replacement?
					☐ Yes ☐ No
					☐ Yes ☐ No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ _____

11 SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY (VUL only)

11a Have you, the proposed Primary Insured, and Applicant/Owner, if other than the proposed Primary Insured, received the current Prospectus for the policy? ☐ Yes ☐ No

11b **Do you understand that the Death Benefit may be variable or fixed under specified conditions?** ☐ Yes ☐ No

11c **DO YOU UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE ENTIRE AMOUNT OF THE POLICY CASH VALUE MAY INCREASE OR DECREASE DEPENDING UPON THE INVESTMENT EXPERIENCE?** ☐ Yes ☐ No

11d With this in mind, is the policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No

12 TRANSFER AUTHORIZATION – TO BE COMPLETED BY APPLICANT/OWNER (VUL only)

(See Prospectus for transfer procedures.)

Your policy applied for, if issued, will automatically include transfer privileges described in the applicable prospectus. These privileges allow the Owner and the registered representative of record to make transfers, where permitted and to change the allocation of future payments unless declined below.

Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

☐ The registered representative does **not** have authority to make transfers or change payment allocations on my behalf.

13 OTHER INSURANCE–TO BE COMPLETED BY THE AGENT/REGISTERED REPRESENTATIVE

13a Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

13b If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No
(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

13c Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

14 ILLUSTRATION CERTIFICATION

The box below must be checked if a signed illustration is NOT enclosed with an application for any IUL policy.

☐ The Applicant/Owner and the Licensed Agent/Registered Representative represent that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. Licensed Agent/Registered Representative's statement: By signing this application, I, the Licensed Agent/Registered Representative represent that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

15 PROPOSED ADDITIONAL/OTHER INSURED **SPECIFIED AMOUNT $**_____

AIR/OIR Beneficiary: ☐ **Owner** ☐ **Primary Insured** ☐ **Same beneficiary as the base policy**

a. Last Name | First Name | M.I.

b. Address (Cannot be a PO Box) | Apt# | City

State | Zip Code | c. Home Phone | d. Driver License Number | State

e. Sex ☐ Male ☐ Female | f. Date of Birth | g. Place of Birth – State/Country | h. Social Security Number

i. Height ft. in. | j. Weight lbs. | k. Marital Status | l. Relationship to proposed Primary Insured

m. Employer's Name, Address and Phone Number

n. Occupation & Duties | # Years

o. Gross Income Current Year $ _____ Gross Income Previous Year $ _____ Net Worth $ _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

p. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

q. How many years has the proposed Insured resided in the USA? _____

r. Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

s. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

t. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

16 PROPOSED ADDITIONAL/OTHER INSURED **SPECIFIED AMOUNT $**_____

AIR/OIR Beneficiary: ☐ **Owner** ☐ **Primary Insured** ☐ **Same beneficiary as the base policy**

a. Last Name | First Name | M.I.

b. Address (Cannot be a PO Box) | Apt# | City

State | Zip Code | c. Home Phone | d. Driver License Number | State

e. Sex ☐ Male ☐ Female | f. Date of Birth | g. Place of Birth – State/Country | h. Social Security Number

i. Height ft. in. | j. Weight lbs. | k. Marital Status | l. Relationship to proposed Primary Insured

m. Employer's Name, Address and Phone Number

n. Occupation & Duties | # Years

o. Gross Income Current Year $ _____ Gross Income Previous Year $ _____ Net Worth $ _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

p. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

q. How many years has the proposed Insured resided in the USA? _____

r. Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

s. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

t. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

17 CHILDREN'S BENEFIT RIDER **Specified Amount $ _____**

Name	Relationship	Date of Birth (month/day/year)	Height (ft., in.)	Weight (lbs.)

Are all children listed? ☐ Yes ☐ No Are all children living with proposed Primary Insured? ☐ Yes ☐ No

If not, explain why: _____

MEDICAL QUESTIONS – Each question must be individually asked and answered for each child proposed for insurance.

Give the details to "Yes" answers below:

A) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No
2) Asthma, emphysema, chronic bronchitis, tuberculosis, or any other respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No
3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No
4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No
5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Received treatment or counseling for or been advised by a member of the medical profession to limit or discontinue the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test **(excludes any test related to a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection)?** ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

C) To the best of your knowledge and belief, within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? ☐ Yes ☐ No

D) Has any proposed Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Child's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

18 AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION Western Reserve Life Assurance Co. of Ohio (the Company)

Each proposed Insured, and I, the Applicant/Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. I/We agree: (A) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any insurance issued on this application; (B) that the Agent/Registered Representative does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application. No waiver or modification shall be binding upon the Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary; (C) except as provided in the Conditional Receipt, if issued, with the same proposed Primary Insured as on this application, any policy on this application shall not take effect until after all of the following conditions have been met: 1) the minimum initial premium must be paid and received by the Company; 2) the Applicant/Owner has personally received and accepted the policy during the lifetime of and while each proposed Insured is in good health, and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the insurance policy will not take effect if the facts have changed.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have 60 days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

TAXPAYER IDENTIFICATION CERTIFICATION

By signing below, the proposed Owner certifies under penalties of perjury that (1) the Social Security Number or other Taxpayer Identification number ("TIN") listed in this application is my correct TIN; (2) I am not subject to backup withholding due to failure to report interest and dividend income (Strike this clause if it is incorrect); and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed Form W-8BEN or other appropriate Form W-8.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The Internal Revenue Service does not require your consent to any provision of this form other than the certifications required to avoid backup withholding.

Signed at _____ _____ on _____
City State Month/Day/Year

_____ _____
Signature of proposed Insured

Signature of Applicant/Owner if other than proposed Insured
(If business insurance, show title of officer and name of firm)

_____ _____
Owner's e-mail address

Print Agent/Registered Representative's Name

_____ _____
Signature of proposed Additional/Other Insured

Signature of proposed Additional/Other Insured

_____ _____
Signature of Agent/Registered Representative

Agent/Registered Representative Number

INSTRUCTIONS FOR CONDITIONAL RECEIPT

DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:

1. any proposed Insured has been treated for or experienced, within the last 12 months, any disorder of the heart, stroke, or other vascular disease, cancer, or HIV infection, or
2. the amount applied for under the attached application exceeds $1,000,000.

IF NO PROPOSED INSURED IS DISQUALIFIED BY ONE OR MORE OF THE FACTORS LISTED IN 1 - 2 ABOVE, YOU MAY COLLECT MONEY AT THE TIME THE APPLICATION PART 1 IS COMPLETED.

Make all checks payable to Western Reserve Life Assurance Co. of Ohio. Do not make checks payable to the Agent/Registered Representative or leave the payee blank, otherwise this Receipt cannot become effective. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application.

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application

dated _____ , with _____ as the proposed Primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Western Reserve Life Assurance Co. of Ohio (the Company), this Receipt is signed by an Agent/Registered Representative or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

There is no conditional coverage for anyone other than the proposed Primary Insured named in the application or for riders or any additional benefits, if any, for which you have applied.

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received by the Company within the lifetime of the proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received by the Company;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable under the Company's rules for insurance at the Rate Class and Tobacco Classification applied for and in the amount and for the plan applied for.

TERMINATION OF CONDITIONAL COVERAGE: Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date Part 1 of the application was signed; (b) the date the Company mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the coverage for which you have applied.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $500,000.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if the proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Western Reserve Life Assurance Co. of Ohio. The Agent/Registered Representative has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the Agent/Registered Representative, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

Dated at _____ on _____ _____

City, State Date Signature of proposed Insured

_____ _____

Signature of Applicant (if other than proposed Insured) Signature of Agent/Registered Representative or Authorized Company Rep

You should retain a copy of this Receipt and Acknowledgment.

Submit with the application and payment.

NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our Agent/Registered Representative may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, [4333 Edgewood Road NE, Cedar Rapids, Iowa 52499].

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

Agent/Registered Representative's Report
(all sections must be completed)

1. **Type of Sale** (check only one box)
   ☐ Personal/Family
   ☐ Business Planning
   ☐ Estate Planning

   Supplemental Purpose of Policy (check only one box)

Business	Personal/Family
☐ Key Employee	☐ Mortgage
☐ Executive Bonus	☐ Retirement
☐ Deferred Compensation	☐ Education
☐ Split Dollar	☐ Income to Family
☐ Buy/Sell - Is Partner applying for similar amount? ☐ Yes ☐ No	☐ Cash Accumulation
Name of Partner _____	Estate Planning
☐ Other _____	☐ Estate Liquidity
	☐ Wealth Replacement

2. Was this plan sold, presented or illustrated as a single employer welfare benefit plan as defined under IRC Section 419?
   ☐ Yes ☐ No
3. a) How long have you known the proposed Insured?
   _____
   b) Relationship to proposed Insured:_____
   _____
   c) Are you financially responsible for the proposed Insured?
   ☐ Yes ☐ No
4. Is the proposed Insured or Owner a licensed Representative of any Broker/Dealer? ☐ Yes ☐ No If yes, name and address of Broker/Dealer _____
   _____
   _____
5. Is the proposed Insured or Owner related to any affiliated Broker/Dealer officer or employee? ☐ Yes ☐ No
   If yes, name and address of Broker/Dealer _____
   _____
6. Did you give the "Notice of Information Practices" to the proposed Insured? ☐ Yes ☐ No
7. Are you submitting or do you plan to submit another application on any proposed Insured listed to WRL or any other company?
   ☐ Yes ☐ No
   Company Name _____
   Face amount $ _____
   Total face amount to be placed with all companies $_____
8. Did you ask all questions in the physical presence of the proposed Insured? ☐ Yes ☐ No
9. Are you aware of anything about the health, habits, hazardous sports, environment or mode of living, which may affect the insurability of any person proposed for insurance?
   ☐ Yes ☐ No
10. Financial Information of Applicant/Owner **if other** than the proposed Insured:
    Gross Income Current Year: $_____.____
    Current Net Worth: $_____.____
11. Will any portion of the initial or subsequent premiums for this policy be paid with borrowed funds? ☐ Yes ☐ No
    If yes, explain _____
12. Will any portion of the initial or subsequent premiums for this policy be paid by a third party? ☐ Yes ☐ No
    If yes, explain _____
13. Did you comply with all requirements relative to obtaining Informed Consent for HIV and AIDS testing? ☐ Yes ☐ No
14. Identification Verification
    Identification was viewed during face to face sale? ☐ Yes ☐ No
    Type of Government issued photo ID _____
    Issuer of Identification Document _____
    Number_____ Expiration Date _____
15. Is the Agent/Registered Representative or Split Agent/Registered Representative also the Owner, Applicant or Payor? ☐ Yes ☐ No
16. Writing Agent/Registered Representative Name
    _____
    Agent/Registered Representative No. _____
    Agent/Registered Representative's Telephone Number
    _____
    Agent/Registered Representative's Fax Number
    _____
    Agent/Registered Representative's E-Mail
    _____
    Percent of Agent/Registered Representative's Split
    _____
    Split Agent/Registered Representative Name
    _____
    Agent/Registered Representative No._____
    Percent of Agent/Registered Representative's Split _____
17. Was money taken with the application? ☐ Yes ☐ No
    If "yes", was the Conditional Receipt completed and given to the applicant? ☐ Yes ☐ No

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of the person(s) seeking to open this policy and verified that person seeking to open this policy is the same person in the documents reviewed. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action or prosecution for violation of state or federal criminal laws.

$_____ has been paid by the Applicant with this application.

_____ _____

Signature of Writing Agent/Registered Representative | Date

PAYOR'S CHECK-O-MATIC PREMIUM PAYMENT PLAN (Automatic Bank Draft)

Authorization to Insurance Company

The Premium Payor hereby authorizes Western Reserve Life Assurance Co. of Ohio to debit his/her account or accounts by means of check or draft drawn or other order made whether by electronic or paper means at the below named financial institution for premiums that may become due under the policy as a result of this application. This authorization is to remain in effect until written notice of revocation is received at the Administrative Office of the Company or until the Check-O-Matic Premium Payment Plan is terminated in a manner provided below. I (We) expressly agree to all conditions applicable to the Check-O-Matic Premium Payment Plan including those appearing below.

Authorization to Financial Institution

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks, drafts and other orders whether by electronic or paper means, with such debits made to my account and drawn or directed by Western Reserve Life Assurance Co. of Ohio to its own order, provided there are sufficient collected funds in said account to pay the same upon presentation. Until you receive written cancellation of this authorization by me (or either of us), you are fully protected when you honor any of those orders. You may, however, discontinue this arrangement by giving 30 days written notice to me (or either of us) and the insurance company. Your treatment of and your rights regarding those orders, shall be the same as if I signed or initiated them. If any of those orders are not honored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability if insurance is forfeited as a result. Notice of charge for debit is hereby waived.

Initial Payment (Must Check One Box)

☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.

☐ AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.

Account Information

TAPE VOIDED CHECK HERE

If not attaching void check or if withdrawing from Savings Account, complete the following information

Bank Name, Office or Branch

Payor Name(s)

Check one: ☐ Checking ☐ Savings

Transit Routing Number

Account Number

Complete the Following Information for Future Recurring Payments

Premium to Withdraw	☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
$ _____	☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

Signature

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X _____ **Date:** _____

Conditions Applicable to Check-O-Matic Premium Payment Plan

No check, draft or any other orders, either by electronic or paper means, shall constitute payment until the Company actually receives payment thereof within the period provided in the policy.

The Check-O-Matic Premium Payment Plan may be terminated by either party by giving written notice to the other.

The Check-O-Matic Premium Payment Plan does not in any manner amend or alter the terms and provisions of any policy, contract or agreement except as may be specifically stated in a policy endorsement or properly executed contract amendment.

For changes or questions call: Toll-free 1-800-851-9777

Or Write: Western Reserve Life Assurance Co. of Ohio, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

Western Reserve Life Assurance Co. of Ohio
Home Office: Columbus, Ohio
Mailing Address: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]
Administrative Office: [PO Box 5068, Clearwater, FL 33758-5068]

WRL Express Application Part I

1 PROPOSED PRIMARY INSURED

Last Name | First Name | M.I.

Street Address (Cannot be a PO Box)

City | State | Zip

Daytime Telephone Number | Date of Birth (Month/Day/Year) | Place of Birth (State/Country)

Social Security Number | Sex | Driver's License Number | State

ft. in. | lbs.
Height | Weight | Marital Status

2 APPLICANT/OWNER The person or entity exercising the policy's granted rights.

☐ Same as proposed Insured
If ownership is a corporation, partnership or institutional body, please complete the Entity Certification of Authority Form. If ownership is a trust, please complete the Trustee Certification Trust Form. Attach a copy of the first page and the signature page of the trust.

Last Name | First Name | M.I.

Street Address (Cannot be a PO Box)

City | State | Zip

SSN/Tax ID | DOB / Trust Date | Relationship to Insured

Are you a citizen of ☐USA ☐Other Country _____ Type of VISA _____

3 PRIMARY BENEFICIARY If percentage shares are not listed below, proceeds will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

4 CONTINGENT BENEFICIARY If percentage shares are not listed below, proceeds will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

5 INSURANCE

Plan:

☐ WRL Freedom Global IUL
☐ WRL Freedom Index UL
☐ WRL Freedom Elite Builder II VUL
☐ WRL Freedom Choice Term II ☐10 ☐15 ☐20 ☐30

Specified Amount: $ _____

Death Benefit Option: (if applicable)

☐ Level Benefit ☐ Increasing Benefit
☐ Increasing to Age 70 then grade to Level

Additional Benefits: Not all items available with all products.

☐ Primary Insured Rider Plus $ _____
☐ Base Insured Rider $ _____
☐ Disability Income Rider (monthly benefit) $ _____
☐ Disability Waiver of Monthly Deductions Rider
☐ Disability Waiver of Premium Rider
☐ Accidental Death Benefit Rider $ _____
☐ Critical Illness Rider $ _____
☐ Inflation Fighter Rider

Life Insurance Compliance Test: (if applicable)

☐ Guideline Premium Test (GPT)
☐ Cash Value Accumulation Test (CVAT)

Rate Class:

☐ Preferred Elite ☐ Preferred Plus ☐ Preferred
☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

Additional/Other Insureds:

☐ Please complete Additional/Other Insured Sections 15 and 16
☐ AIR Disability Income Rider
(monthly benefit) $ _____

Children's Benefit Rider:

☐ Please complete Child Insured Section 17

6 PREMIUMS PAYABLE

6a Initial Planned Premium $ _____
☐ Electronic (bank draft) _____ Draft Date (1st thru 28th) ☐ Direct Bill ☐ Other _____
☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly

6b A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.

_____
Secondary Addressee

_____
Street Address (Cannot be a PO Box) City State Zip

7 PREMIUM ALLOCATIONS

Global IUL & IUL

Indicate your premium allocation percentages below. Total must equal 100% and must be whole percents only.

_____ % Index Account
_____ % Basic Interest Account
100% Total

VUL

Complete and sign the Premium Allocation Options form.

8 INFORMATION ABOUT THE PROPOSED PRIMARY INSURED

8a Best days and times to call for telephone interview? _____

Best time to call to set up your exam? _____ Telephone Number: _____

8b Name of Employer: _____ Occupations/Duties: _____

_____ _____

8c Gross Income Current Year $_____ Gross Income Previous Year $ _____

Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange

☐ Other _____

Net Worth $_____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

8d Are you a citizen of ☐ USA ☐ Other Country_____ Type of VISA _____

8e How many years has the proposed Insured resided in the USA? _____

8f Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

9 INFORMATION ABOUT PROPOSED INSUREDS

Has any proposed Insured:

9a Used TOBACCO or any other product containing nicotine in the past 5 years? ☐ Yes ☐ No

If Yes, please give type and date last used:

Type: _____ Date Last Used: _____

9b To the best of your knowledge and belief, during the last 10 years, been diagnosed or treated by a licensed member of the medical profession for heart, liver, kidney, lung, brain or mental or nervous disorder, stroke, diabetes, cancer, AIDS or ARC (AIDS Related Complex), alcohol or drug abuse? ☐ Yes ☐ No If Yes, please provide personal physician or clinic information and details:

Name:_____

Address: _____

Telephone Number: _____ Details (including date last consulted): _____

_____

_____

9c Flown in the past 2 years or plan to fly within the next 2 years, except as a passenger on a regularly scheduled flight?
☐ Yes ☐ No If Yes, complete Avocation & Aviation Questionnaire.

9d Within the past 2 years, participated in:

a) Aeronautics such as hang-gliding, ballooning, ultra-light flying or skydiving? ☐ Yes ☐ No

b) Organized motor vehicle, motorcycle, boat or powered vehicle racing? ☐ Yes ☐ No

c) Skin or scuba diving, mountain climbing, canyoneering, rodeos or competitive skiing? ☐ Yes ☐ No

If Yes, complete Avocation & Aviation Questionnaire.

9e Had your driver's license suspended, restricted, revoked, or been cited for a moving violation in the past 5 years? ☐ Yes ☐ No
If Yes, please explain: _____

_____

_____

9f Been convicted of a misdemeanor (other than a minor traffic violation) or felony, or been on probation or parole in the past 10 years?
☐ Yes ☐ No If Yes, please explain: _____

_____

_____

10 OTHER INSURANCE FOR ALL PROPOSED INSUREDS: In force or for Replacement

10a Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain. _____ ☐ Yes ☐ No

_____

_____

_____

10b Is there an application for life, disability, accident, sickness or critical illness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent/Registered Representative's Report. ☐ Yes ☐ No

10c Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

10d Does any proposed Insured have existing life, disability, accident, sickness or critical illness insurance or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of Insurance	Year Issued	Replacement?
					☐ Yes ☐ No
					☐ Yes ☐ No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ _____

11 SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY (VUL only)

11a Have you, the proposed Primary Insured, and Applicant/Owner, if other than the proposed Primary Insured, received the current Prospectus for the policy? ☐ Yes ☐ No

11b **Do you understand that the Death Benefit may be variable or fixed under specified conditions?** ☐ Yes ☐ No

11c **DO YOU UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE ENTIRE AMOUNT OF THE POLICY CASH VALUE MAY INCREASE OR DECREASE DEPENDING UPON THE INVESTMENT EXPERIENCE?** ☐ Yes ☐ No

11d With this in mind, is the policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No

12 TRANSFER AUTHORIZATION – TO BE COMPLETED BY APPLICANT/OWNER (VUL only)

(See Prospectus for transfer procedures.)

Your policy applied for, if issued, will automatically include transfer privileges described in the applicable prospectus. These privileges allow the Owner and the registered representative of record to make transfers, where permitted and to change the allocation of future payments unless declined below.

Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

☐ The registered representative does **not** have authority to make transfers or change payment allocations on my behalf.

13 OTHER INSURANCE–TO BE COMPLETED BY THE AGENT/REGISTERED REPRESENTATIVE

13a Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

13b If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No
(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

13c Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

14 ILLUSTRATION CERTIFICATION

The box below must be checked if a signed illustration is NOT enclosed with an application for any IUL policy.

☐ The Applicant/Owner and the Licensed Agent/Registered Representative represent that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. Licensed Agent/Registered Representative's statement: By signing this application, I, the Licensed Agent/Registered Representative represent that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

15 PROPOSED ADDITIONAL/OTHER INSURED **SPECIFIED AMOUNT $**_____

AIR/OIR Beneficiary: ☐ **Owner** ☐ **Primary Insured** ☐ **Same beneficiary as the base policy**

a. Last Name | First Name | M.I.

b. Address (Cannot be a PO Box) | Apt# | City

State | Zip Code | c. Home Phone | d. Driver License Number | State

e. Sex ☐ Male ☐ Female | f. Date of Birth | g. Place of Birth – State/Country | h. Social Security Number

i. Height ft. in. | j. Weight lbs. | k. Marital Status | l. Relationship to proposed Primary Insured

m. Employer's Name, Address and Phone Number

n. Occupation & Duties | # Years

o. Gross Income Current Year $ _____ Gross Income Previous Year $ _____ Net Worth $ _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

p. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

q. How many years has the proposed Insured resided in the USA? _____

r. Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

s. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

t. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

16 PROPOSED ADDITIONAL/OTHER INSURED **SPECIFIED AMOUNT $**_____

AIR/OIR Beneficiary: ☐ **Owner** ☐ **Primary Insured** ☐ **Same beneficiary as the base policy**

a. Last Name | First Name | M.I.

b. Address (Cannot be a PO Box) | Apt# | City

State | Zip Code | c. Home Phone | d. Driver License Number | State

e. Sex ☐ Male ☐ Female | f. Date of Birth | g. Place of Birth – State/Country | h. Social Security Number

i. Height ft. in. | j. Weight lbs. | k. Marital Status | l. Relationship to proposed Primary Insured

m. Employer's Name, Address and Phone Number

n. Occupation & Duties | # Years

o. Gross Income Current Year $ _____ Gross Income Previous Year $ _____ Net Worth $ _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 thru 70 and $1,000,000 for ages 71 and up.

p. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

q. How many years has the proposed Insured resided in the USA? _____

r. Will you be traveling outside of the United States in the next 12 months? ☐ Yes ☐ No If yes, provide details including destination, number of trips, duration and purpose of each trip. _____

_____

_____

s. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

t. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco

17 CHILDREN'S BENEFIT RIDER **Specified Amount $ _____**

Name	Relationship	Date of Birth (month/day/year)	Height (ft., in.)	Weight (lbs.)

Are all children listed? ☐ Yes ☐ No Are all children living with proposed Primary Insured? ☐ Yes ☐ No

If not, explain why: _____

MEDICAL QUESTIONS – Each question must be individually asked and answered for each child proposed for insurance.

Give the details to "Yes" answers below:

A) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No
2) Asthma, emphysema, chronic bronchitis, tuberculosis, or any other respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No
3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No
4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No
5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Received treatment or counseling for or been advised by a member of the medical profession to limit or discontinue the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test **(excludes any test related to a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection)?** ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

C) To the best of your knowledge and belief, within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? ☐ Yes ☐ No

D) Has any proposed Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Child's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

18 AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION Western Reserve Life Assurance Co. of Ohio (the Company)

Each proposed Insured, and I, the Applicant/Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. I/We agree: (A) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any insurance issued on this application; (B) that the Agent/Registered Representative does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application. No waiver or modification shall be binding upon the Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary; (C) except as provided in the Conditional Receipt, if issued, with the same proposed Primary Insured as on this application, any policy on this application shall not take effect until after all of the following conditions have been met: 1) the minimum initial premium must be paid and received by the Company; 2) the Applicant/Owner has personally received and accepted the policy during the lifetime of and while each proposed Insured is in good health, and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the insurance policy will not take effect if the facts have changed.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have 60 days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

TAXPAYER IDENTIFICATION CERTIFICATION

By signing below, the proposed Owner certifies under penalties of perjury that (1) the Social Security Number or other Taxpayer Identification number ("TIN") listed in this application is my correct TIN; (2) I am not subject to backup withholding due to failure to report interest and dividend income [Strike this clause if it is incorrect]; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed Form W-8BEN or other appropriate Form W-8.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The Internal Revenue Service does not require your consent to any provision of this form other than the certifications required to avoid backup withholding.

Signed at _____ _____ on _____
City State Month/Day/Year

_____ _____
Signature of proposed Insured

Signature of Applicant/Owner if other than proposed Insured
(If business insurance, show title of officer and name of firm)

_____ _____
Owner's e-mail address

Print Agent/Registered Representative's Name

_____ _____
Signature of proposed Additional/Other Insured

Signature of proposed Additional/Other Insured

_____ _____
Signature of Agent/Registered Representative

Agent/Registered Representative Number

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application

dated _____ , with _____ as the proposed Primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Western Reserve Life Assurance Co. of Ohio (the Company), this Receipt is signed by an Agent/Registered Representative or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

There is no conditional coverage for anyone other than the proposed Primary Insured named in the application or for riders or any additional benefits, if any, for which you have applied.

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received by the Company within the lifetime of the proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received by the Company;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable under the Company's rules for insurance at the Rate Class and Tobacco Classification applied for and in the amount and for the plan applied for.

TERMINATION OF CONDITIONAL COVERAGE: Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date Part 1 of the application was signed; (b) the date the Company mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the coverage for which you have applied.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $500,000.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if the proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Western Reserve Life Assurance Co. of Ohio. The Agent/Registered Representative has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the Agent/Registered Representative, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

Dated at _____ on _____ _____

City, State Date Signature of proposed Insured

_____ _____

Signature of Applicant (if other than proposed Insured) Signature of Agent/Registered Representative or Authorized Company Rep

You should retain a copy of this Receipt and Acknowledgment.

Submit with the application and payment.

NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our Agent/Registered Representative may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, [4333 Edgewood Road NE, Cedar Rapids, Iowa 52499].

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.